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QUALITATIVE STUDY OF WELCOME HOUSES: A RECENT INITIATIVE DESIGNED TO IMPROVE RETENTION IN THERAPEUTIC COMMUNITIES

ABSTRACT

Background: Welcome houses (WHs) have been introduced as a stage at the start of some European therapeutic communities (TCs) to improve treatment retention. In contrast to the structured, rule-bound approach of many residential therapeutic facilities (often described as ‘total institutions’), WHs provide a relatively ‘gentle’ introduction to residential life. This paper explores the influence of WHs on treatment retention from the perspective of TC staff and residents. **Methods:** Thirty-five qualitative interviews were conducted in two TCs with WHs in the United Kingdom. Participants included staff (n=13), current residents (n=13) and former residents (n=9). Interviews were transcribed, coded and analyzed using Framework. **Results:** Participants reported that retention was affected by three core factors: ‘intensive care and support’, ‘rules and order’ and ‘time and space’. Each factor was described as influencing retention both positively and negatively, but via different mechanisms. WHs seemed to increase retention amongst people who had never been in residential treatment previously or who had complex needs, but decrease retention amongst those who were more stable at treatment entry. **Conclusions:** WHs retain many of the core characteristics of total institutions, but in an adapted ‘softer’ form. As such, WHs might be better described as ‘reinventive institutions’. WHs should not be a mandatory stage within TCs. Rather TC providers should consider each new resident’s need for WH as part of their assessment. Further research is needed to quantify the impact of WHs on retention and to test apparent associations between retention outcomes and resident characteristics.

KEY WORDS: Substance misuse, therapeutic communities, retention, welcome house, total institution, qualitative.

INTRODUCTION

This paper focuses on welcome houses (WHs), a relatively recent initiative in some European therapeutic communities (TCs). Created as a ‘first’ stage of treatment, WHs aim to provide new TC clients with a relatively ‘gentle’ introduction to life within the community; the expectation being that this will better prepare them for the demands of treatment and ultimately improve treatment retention (Goethals et al., 2012; Goethals et al., 2015; Vandeveld, 2014). The WH stage has similar assimilation objectives to the traditional TC ‘induction’ or ‘orientation’ stage (Condelli, 1994; De Leon, 2000; Goethals et al., 2012; Harrison et al., 2007); yet, unlike the induction stage, WH residents do not participate in all activities of the daily TC programme straightaway (De Leon, 2000). Anecdotal evidence suggests that WHs have led to longer residential treatment stays and higher treatment completion rates (Vandeveld, 2014). However, there has been no empirical research exploring ‘how’ WHs might have achieved this (Goethals et al., 2015).

The concept of the ‘total institution’ (TI) provides a useful framing heuristic for our paper. The term ‘total institution’ has, over the years, been applied to a diverse range of residential settings, such as prisons, psychiatric hospitals, boarding schools, and nursing homes (Goffman, 1961a, b). TIs have been defined as places ‘of residence and work where a large number of like-situated individuals, cut-off from wider society for an appreciable period of time, together lead an enclosed, formally administered round of life’ (Goffman, 1961a, b). Despite their various forms, TIs share a number of key characteristics, including segregation from those outside the institution, structure, routines, rules, obedience, conformity, lack of privacy, a hierarchical authority system, and restrictions on self-determination (Goffman, 1961a, b). Critically, they seek to ‘resocialize’ people by eroding their previous negative identities and providing them with new positive socialisation experiences.

Historically, TCs have been described as TIs (c.f. Ogborne & Melotte, 1977; Sansone, 1980). TCs have been an established approach to residential addiction treatment since the late 1950s (De Leon, 2000; Goethals et al., 2011; Toon & Lynch, 1994). In the United States of America (USA), the early ‘concept house’ approach to TCs was based on the notion of a self-supporting ‘community’ that operated according to a strict hierarchical structure, punitive regimes and few privileges (Goethals et al., 2011; Toon & Lynch, 1994). Residents were publically subjected to harsh and sometimes humiliating confrontation in the name of rehabilitation, the aim being to strip them of their ‘destructive’ behaviours and ‘addict’ identities and to promote ‘better’ drug and alcohol free lives (Goethals et al., 2011).

As the TC model spread from the USA, it evolved in response to different social and cultural contexts (Broekaert, 2006; Debaere, Vanheule & Inslegers, 2014; Ronel, et al., 2013). Today, there are over 1,200 TC-related programmes in Europe alone (Vanderplasschen, Vandeveld & Broekaert, 2014). In contemporary TCs, residents still collectively determine codes of acceptable behaviour to guide community members so that they develop ‘appropriate’ social, educational, and life skills, change their negative behaviours, and remain abstinent (De Leon, 2000). Nonetheless, contemporary TCs are more varied and less restricted than the original American TCs, and the types of punishment used for transgressions of community codes tend to be ‘softer’ (Broekaert, 2006; De Leon, 2000; Goethals et al., 2011). With these recent modifications, the differences between TCs and other types of residential rehabilitation programmes have become less easy to discern and we might now question whether or not contemporary TCs can really still be regarded as TIs.

Nowadays, TCs resemble other residential drug and alcohol services in that they tend to cater for individuals with relatively complex needs and entrenched substance use histories (NICE, 2007; National Treatment Agency, 2012). They are also more expensive than community treatment programmes

(Keen et al., 2001; National Treatment Agency, 2012). Research suggests that longer retention in residential treatment is a predictor of improved substance use outcomes both during (Malivert et al., 2012; Smith, Gates & Foxcroft, 2006; Vanderplasschen et al., 2013) and after treatment (Gossop et al., 1999; Hubbard et al., 1997; Moos, Moos & Andrassy, 1999; Vanderplasschen et al., 2013). Consequently, it is of on-going concern that clients often leave residential services before completing their programme (Broekaert, 2006; Gossop et al., 1999; National Treatment Agency, 2012; Newton-Howes & Stanley, 2015). During 2010-2011, almost 50% of residential clients in England left treatment in the first two weeks and more than 60% left in the first month (National Treatment Agency, 2012). TC residents also routinely leave treatment during the first month (Darke, Campbell & Popple, 2012; Harrison et al., 2007; Keen et al., 2001; Malivert et al., 2012).

A complex range of factors has been identified as affecting TC treatment retention. Reasons for non-completion include clients' poor motivation, low expectations of treatment success, heavier substance use on treatment entry, limited attachment to the programme ideology, lack of identification with other residents or staff, as well as insufficient counselling (Darke, Campbell & Popple, 2012; Goethals et al., 2015; Joe, Simpson & Broome, 1998; Keen et al., 2001; Ravndal & Vaglum, 1994). In contrast, factors that have been associated with good TC retention include clients' social conformity, successful detoxification prior to treatment, previous episodes of successful treatment, being inducted into the TC, and the existence of strong therapeutic alliances between staff and residents (Darke, Campbell & Popple, 2012; Harrison et al., 2007; Keen et al., 2001; Lang & Belenko, 2000).

With little clear evidence or guidance on how to encourage substance misusers to stay in treatment, TCs have introduced a range of initiatives in recent years. These have included changing staffing structures (De Leon et al., 2000), altering induction procedures (Harrison et al., 2007), and providing more interventions and support in the community before residential treatment (Staiger et al., 2014; Vanderplasschen, Vandevelde & Broekaert, 2014; Vandevelde et al., 2015). WHs constitute an additional innovation, but they need further empirical investigation prior to any widespread

implementation. In this paper, we use qualitative data to explore how those living and working in TCs believe WHs affect treatment duration. Given the difficulties of conducting experimental designs in real world settings and attributing ‘cause’ to complex social interventions, we did not seek to ascertain whether or not, or by how much, WHs increased retention. Indeed, we remained open to the possibility that WHs may affect retention in different ways for different clients.

METHODS

Setting

The study was conducted in two TCs located in different areas of the UK. The services were run by the same parent organisation, operated the same model of treatment delivery, and had both introduced WHs in 2009. Each service could each accommodate 35 residents, including up to 10 WH residents. In contrast to the arrangement in many European WHs, the two study WHs were not actual buildings or detached physical spaces. Rather, residents in the WH stage lived in the same ‘houses’ and shared the same daily living areas as residents who were in more advanced stages of treatment, although they attended separate treatment groups. Senior staff and managers of our two study services reported that retention amongst their clients had improved and unplanned departures had reduced since they had introduced WHs (Aslan, 2013).

The WH stage lasted four to eight weeks and sought to prepare all new residents for the main residential treatment programme. At the time of the study, the main treatment programme

typically lasted a further 22 weeks. During the WH stage, residents were offered detoxification, if they had not already detoxified elsewhere, provided with detailed explanations of the main treatment, and allocated a key-worker and a peer to 'buddy' and support them. They were also exempted from formal responsibilities (such as household duties) and from sanctions should they contravene the codes of acceptable behaviour as determined by the main community.

Data collection

Ethical approval for our study was received from a university research ethics committee. All staff and current TC residents were informed of the study by the researcher, CT. As the researcher did not have access to client records, staff contacted former residents about the study. Staff either asked former residents to telephone the researcher if they were interested in taking part or sought their permission to pass contact details onto the researcher. A member of staff from the organization's Head Office also contacted (by mail or telephone) every client who had left either of the services prematurely within the six months prior to the start of the research. All interested individuals were given written and verbal information about the study and time to decide whether or not they wanted to take part. CT then purposively sampled participants to include those likely to have a range of views of the WHs (i.e. staff of different grades, current and former residents, and residents who had completed the WH stage successfully as well as those who had left prematurely). Of those invited to interview, none refused.

Between October 2015 and March 2016, CT conducted 35 semi-structured interviews with staff and current and former residents. Prior to being interviewed, all participants were assured

of their anonymity and provided written informed consent. Separate topic guides were used for the staff and resident interviews, although both followed the same broad format and covered participants' personal circumstances as well as their views and experiences of the WH stage and residential treatment more generally. All interviews took place in private, lasted between 41 and 99 minutes, and were audio-recorded. No reimbursement was made to staff or current residents, but former residents received a £10 high street gift card in compensation for their time.

Data management and analysis

All interviews were transcribed verbatim by a professional transcriber and the transcriptions were imported into the qualitative software programme MaxQDA (v11) for systematic indexing. Separate code systems were created for the staff and resident interviews, and these each comprised deductive codes (derived from the topic guides) and inductive codes (which emerged from the interviews). CT indexed all transcriptions by assigning sections of text to the relevant codes until all the data were assigned. Data relating to retention were indexed to a specific 'retention' code.

For the analyses, the retention data were exported from MaxQDA into a Microsoft Word document. This was then reviewed line by line using Iterative Categorisation to generate initial descriptive themes (Neale, 2016). Themes were next explored using a Framework approach (Ritchie & Spencer, 1994). To this end, the data were re-reviewed, looking for further patterns and more conceptual categories, including similarities and differences between participant subgroups. This process indicated that retention was affected by three core factors: 'intensive care and

support’, ‘rules and order’ and ‘time and space’. In reporting our analyses, we provide anonymised verbatim quotations from residents (R) and staff (S) to illustrate key findings.

RESULTS

Participants

Participating staff (n=13) included both senior organisational staff who had established the WHs (n=3) and operational staff (therapeutic workers, care workers and service and programme managers) who worked in the services (n=10). Participating residents (n=22) were aged between 23 and 57 years (mean age = 41 years). All but two were White British, and their substance use histories ranged from four to 37 years. Thirteen were current residents and nine were former residents. At the time of interview, 10 of the current residents were in the WH stage and three had progressed from the WH stage to the main residential treatment. Of the nine former residents, three had completed the full treatment programme successfully, two had left the WH stage prematurely, and four had completed the WH stage successfully but then left the main TC programme prematurely.

INSERT TABLES 1 AND 2 HERE

Intensive care and support

Both staff and residents explained that entering residential treatment was a daunting step and new residents were particularly vulnerable. Staff additionally noted that WH residents often did not have the skills, confidence, or trust to ask other residents for support. Staff and residents therefore believed that the intensive care and support provided within the WH stage reassured new residents and helped them to settle into the services, thus preventing early departures:

We try to give them [new residents] that more supported, nurturing, 'you're important, you're special to us,' sort of care in welcome house and that early stage. We've always said in the community that the newest people in the community are the most important people, and I think welcome house has helped cement that. (S2, Manager, Service A)

In addition, therapeutic staff explained that they prioritised their WH clients over others in the community, giving each of them at least one hour of key-work every week. Staff in other roles also said that they paid more attention to WH residents and provided them with more support than others. For example, they described chatting with them informally, escorting them to medical appointments, and administering their medications before residents who had been in the service longer.

Residents who had been in the services longer, meanwhile, reported that they shared their own treatment experiences with WH residents and tried to encourage them to remain in treatment, especially if they were struggling or were having doubts about staying. Staff and residents said that support provided by other residents who had been in treatment for longer and who were doing well was particularly important in promoting retention as these 'more treatment experienced' residents acted as role models and exemplified how treatment had benefits over time.

Staff and residents agreed that the intensive care and support during the WH stage was particularly important for residents entering residential treatment for the first time and for residents who arrived with significant needs (for example, those detoxifying or in withdrawal, those with poor health, and those with little external support from friends and family). Staff and residents explained that the extra care and support helped these ‘more vulnerable’ WH residents to develop bonds with staff and other residents. More generally, it encouraged new residents to feel safe, valued, and worthy of treatment:

I’ve had loads of support, loads of support... I was going to go [leave] more than once. [People] coming down that drive, talking me back up... sitting outside my room, checking on me to see if I’m alright. Everyone coming up to me, ‘you alright, you alright?’ (R14, in WH, Service B)

Most WH residents explained how they felt cared for and supported when staff and other community residents were compassionate, friendly towards them, spent time with them, and took their individual needs into account. They said that they appreciated having a ‘buddy’ to answer their questions and provide emotional and practical support during their first few days; although they mostly preferred staff to help them with certain personal or practical issues, such as housing, benefit or health problems.

Despite many reports that the extra care and support offered to residents in WHs increased retention, there were also indicators to the contrary. For example, a minority of WH residents stated that other residents, particularly those who had problems of their own, had not always supported them. Moreover, a small number of residents reported that they had had

disagreements with other residents or said that those who had been in treatment for longer were unsympathetic or authoritarian towards them during the WH stage. In turn, this had made them feel intimidated, unsafe, and unsettled; leading them to question whether or not they should leave:

I had an altercation with another peer that was in welcome house. He was aggressive towards me, verbally, not physically. Obviously he would have been out if he had have been [physically aggressive]. And it really hurt my feelings, and it did make me want to leave, but that got ironed out. (R8, in main treatment, Service A)

Importantly, several residents, who described themselves as living fairly ‘independent’ lives before entering treatment, stated that they had felt ‘suffocated’ and ‘babied’ by the intensity of the support imposed upon them during the WH stage. This, they said, had made them consider leaving the service. Similarly, some WH residents (particularly those who were fully detoxified on admission and who were eager to start the main treatment programme straightaway) reported that they had considered leaving the WH early as they had felt that their needs had been overlooked. Other WH residents reported that they had also considered leaving treatment when they had not had enough personal support, usually if the services had been short-staffed and their named worker had been absent:

You get ignored in welcome house. You’re not important to them until you’ve moved up [to the main treatment stage]. I suppose [in] welcome house, they think you’re going to walk out all the time, so they don’t bother with you. (R10, left WH early, Service A)

Rules and order

Within the two TCs, all residents were required to be abstinent and to behave ‘appropriately’. However, there were fewer expectations of WH residents. For example, WH residents did not need to attend or contribute to WH-only groups if they preferred not to or if they felt tired or unwell. Staff argued that this more lenient approach was in recognition of the fact that new residents could not be expected to know how to behave at the start of treatment. Most staff and residents agreed that reduced expectations and increased tolerance helped new residents settle into, and then remain in, treatment as they were able to make mistakes without worrying about the consequences. Similarly, most WH residents valued this leniency, particularly if they were detoxifying and experiencing withdrawal symptoms:

Welcome house is certainly, you know, it's kept me here kind of thing. It's meant I've not wanted to leave. If I'd gone straight to [main treatment], I might have wanted to leave or something. I might have had thoughts of leaving because I would have probably been sanctioned left, right and centre. (R17, in WH, Service B)

Importantly, however, the more flexible approach during the WH stage was not always considered good for retention. For example, some residents – particularly those who had previously been in prison or who had attended other residential treatment services – said that they were accustomed to, and expected, more punitive approaches with more (severe) consequences. Further, staff and residents complained that some WH residents deliberately took advantage of the ‘softer’ approach and were disruptive in groups or did not contribute to them:

We do have occasions where they [residents] do walk out [of groups], just because they think they can get away with it, because they're in welcome house. Because they can use the excuse that they're feeling unwell... and sometimes people will just walk out of those groups and out of welcome house, because they know the consequences aren't as severe. (S5, Therapeutic Team, Service B)

When WH group facilitators did not intervene to manage unruly residents, those who were keen to do therapeutic work reported that they had sometimes contemplated leaving treatment as they had felt that their own progress was being hampered. In contrast, others – particularly new residents who were accustomed to living independently, managing their own time, and making their own decisions, as well as some who were in residential treatment for the first time – felt that the WH restrictions were ‘petty’. These individuals often stated that they had considered leaving the TCs during WH as they did not believe that they would be able to live within the constraints of the main community and did not think that the ‘rules’ would help their recovery:

From nine o'clock in the morning until half past ten in the morning and you weren't allowed to go out for a cigarette or have a cup of coffee. And I just don't know what that were meant to teach you. Because that wouldn't be part of my structure when I come out... I'm actually an organised person anyway. So maybe for some people that have come off the street and things like that, like maybe they need that sort of structure, yeah. But I were brought up structured anyway... Even when I were drinking, there was still certain things that I put in place. (R18, left WH early, Service A)

Time and space

Both staff and residents reported that the four-week minimum length of stay within the WHs helped most residents settle into the services without feeling rushed, and this improved retention. Similarly, they agreed that having flexibility to extend the WH stage to up to eight weeks was beneficial. In this regard, staff and residents reported that the WH stage offered residents time and space to mentally acclimatize to the service but also to physically recuperate. This, they argued, was especially important for people who were in residential treatment for the first time, in withdrawal, or in poor physical health:

The aim is to make people settle in as best as possible, which affects retention obviously, which is really important, because people really fight to be here. And I think in those early days that kind of flight impulse is so incredibly high, that I think to be able to give them a bit of time away and to not be overwhelmed, that's the key. (S7, Manager, Service A)

During the WH stage, residents spent very little time alone. They lived amongst other residents, were monitored closely by staff and other residents, and had a separate programme of groups and activities. According to staff, this separate programme was not overly demanding; it taught residents how the services operated and introduced them to having more structure in their lives. Staff and residents emphasised that the smaller separate WH groups improved residents' confidence, and enabled them to bond with one another. This was considered especially important in improving retention amongst residents who were more 'vulnerable', such as those who had been isolated before entering the service, those with low self-esteem, those who lacked basic life skills, and those who had been homeless or had histories of offending:

[The] only thing they're really kept away from is some of the [main treatment] groups. Because some of the groups, as I say, can get heated. They can get confronted and it's just a case of, what we don't want to do is get them put in that position where... they want to leave, because they can't cope. (S10, Care Team, Service B)

Conversely, staff and residents also reported that residents who arrived with few immediate physical or mental health problems tended to want to start the main treatment immediately. These residents described feeling bored, restless and frustrated by the slow pace and relative simplicity of the WH programme and explained that they would have preferred to have been more involved in the main treatment from the beginning:

The only thing that can be difficult is we have people come here who have already detoxed or don't require a detox. So four weeks in welcome house when they're not physically detoxing, they want to do more, because physically they're able to do more. So I find that they want to rush through welcome house. (S5, Therapeutic Team, Service B)

Meanwhile, other residents complained of being bored and of having 'nothing to do' when there were gaps in the WH programme:

Welcome house is so boring... You just want to go home and take drugs. You just sit there and think about what you used to, were doing last week, getting off your head. (R10, left WH early, Service A)

Finally, some residents - particularly those who were accustomed to living independently - explained how they had considered leaving WH early as they had wanted more privacy and time to themselves:

There was just no privacy, no privacy at all. If you went to sit where they eat their dinner, somebody would follow you in... You just never got any head space, which were one of my major problems... I found that really frustrating and annoying... because I am a person that does like to be on my own sometimes, just to sort my head out. (R18, left WH early, Service A)

DISCUSSION

Our analyses indicated that three key aspects of the WH experience seemed to influence treatment retention. These were ‘intensive care and support’, ‘rules and order’ and ‘time and space’. Of these, ‘rules and order’ and ‘time and space’ most closely relate to the concept of the ‘total institution’ (TI). That is, they explicitly encompass segregation, structure, routines, obedience, lack of privacy, authority, and restrictions on self-determination (Goffman, 1961a, b). Although ‘intensive care and support’ less obviously links to the traditional notion of a TI, it can be aligned with Scott’s concept of the ‘reinventive institution’ (RI) (Scott, 2010). According to Scott, TIs have become less repressively coercive and more voluntaristic in recent years and the old hierarchical power structure of the TI has been replaced by a more horizontal power arrangement, captured by the term RI. Within RIs, social order and control are maintained through processes of mutual surveillance and resident cultures, rather than force, and individuals proactively seek self-improvement, rather than have it foisted upon them (Scott, 2010).

In our study, ‘intensive care and support’, particularly care and support provided to residents by other residents, was repeatedly associated with retention, suggesting that WHs could potentially be described as RIs. Reflecting this, we found that residents and staff described nurturing, guiding and role modelling others into the TC and along the path of identity reconstruction. Social control was relatively subtle, power was contested, and regulation occurred through solicitous interactions between residents and between residents and staff. Nonetheless, the culture of monitoring and surveillance persisted; a finding that seemed likely to be related to the lack of any geographic separation between the WHs and main stage TCs, as a result of which WH residents could always be physically observed.

Our analyses thus indicated that the WHs retained many of the core characteristics of TIs, albeit often in an adapted ‘softer’ form. WHs may be less hierarchically structured and rule-bound than a traditional TI, but their impact on residents’ willingness to stay in treatment still clearly related to a complex interplay of social conformity, segregation, structure, lack of privacy, authority and restrictions on free action. The next question to consider is how this occurred.

Our data revealed that the ‘softer’ TI-related features within WHs can affect TC retention both positively and negatively, but via different mechanisms. For example, high levels of personalised care and support, particularly from peers, fewer rules and regulations, and segregation through time and space can all potentially promote retention by helping residents settle into residential life and orient themselves to treatment. They may also enable residents to benefit from the experiences of others who are doing well in treatment, learn how to behave without fear of sanction, physically recuperate, and bond with other residents. In contrast, too much personalised care and support can be suffocating and oppressive. Lack of strict rules and

sanctions permits disruptive behaviors and reduces treatment engagement, whilst the relatively undemanding WH daily routine can create boredom and frustration. In these ways, TC treatment retention can be undermined.

In addition, we found that the impact of WHs on retention seemed to be affected by resident characteristics. Specifically, WHs appeared to increase retention amongst people who had never been in any form of residential treatment previously or who had more complex needs. These included those who were detoxifying as well as residents who were socially isolated, had poor health, experienced low self-esteem, and lacked basic life skills. Since these individuals share a similar profile to those who are most likely to leave residential treatment services prematurely (Darke, Campbell & Popple, 2012; Goethals et al., 2015; Joe, Simpson & Broome, 1998; Keen et al., 2001; Meier, 2005; NICE, 2007; National Treatment Agency, 2012; Ravndal & Vaglum, 1994), it would seem that the WH initiative was appropriately catering for those least likely to complete treatment and therefore most in need of support.

In contrast, WHs appeared to frustrate and decrease retention amongst residents who had less complex needs at treatment entry, particularly those who had detoxed or who were living independently before entering the service. Reassuringly, the literature indicates that these individuals are more likely to complete treatment successfully anyway and are therefore less likely to require a retention focused intervention (Darke, Campbell & Popple, 2012; Harrison et al., 2007; Keen et al., 2001; Lang & Belenko, 2000; Meier, 2005). These findings add depth to discussions about the impact of treatment ‘dose’ on retention and treatment completion, suggesting that some individuals will benefit from a more intensive early ‘dose’ of help than others due to their pre-existing high levels of need (Joe, Simpson & Broome, 1998).

Our study has several limitations. First, we did not collect any new quantitative data on retention. Instead we relied on reports from the service provider that retention had improved. Second, our research was conducted in only two TCs which had introduced the WH stage as a concept, rather than as a physically separate space for new residents; this limits the empirical generalisability of our findings. Third, despite extensive efforts, we only interviewed two residents who had left during the WH stage. Although we were able to interview other former residents, including some who had left the main TC programme prematurely, we may not have captured all of the reasons why people did not complete the treatment. Nevertheless, to the best of our knowledge, this is the first qualitative study of WHs, and the first in-depth exploration of how the initiative seemed to be affecting retention. A key strength is that we collected detailed data from a range of service staff and current and former residents, yielding diverse perspectives on how and for whom the initiative had benefits.

CONCLUSIONS

WHs retain many core features of the traditional TI but in an adapted ‘softer’ form, which means that they might be better described as RIs. They appear to meet the needs of, and improve retention amongst, new residents with more complex needs who are the most likely to leave treatment prematurely. However, they can frustrate and potentially undermine retention amongst those who are more independent at treatment entry. These findings suggest that WHs should not be a mandatory stage within TC treatment settings. Rather service providers should consider each individual’s need for the WH stage as part of their assessment procedures, and offer them to individuals most likely to benefit. This would help to ensure that an initiative that can increase retention for some does not inadvertently decrease retention for others. Further

research is now needed to quantify the impact of WHs on retention in a larger number of residential treatment settings and to statistically test the qualitative associations we believe we have identified between retention outcomes and resident characteristics, especially as more services consider introducing the WH concept.

DECLARATION OF INTEREST

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Table 1: Staff characteristics (n=13)

		n	TOTAL n=13
Gender	Male	3	13
	Female	10	
Role	Senior staff	3	13
	Therapeutic Team (facilitate groups in the main programme; key-work)	3	
	Care Team (facilitate WH groups; dispense medication)	2	
	Service manager/ managerial staff	5	
Years working at organisation	Less than 5	7	13
	6 – 10	3	
	11 - 15	1	
	More than 16	2	
Work location	Organisation Head Office (non-service location)	3	13
	Service A	5	
	Service B	5	

Table 2: Resident characteristics by service (n=22)

		Service A	Service B	n	TOTAL n=22
Gender	Male	5	8	13	22
	Female	6	3	9	
Age (years)	20 – 29	1	2	3	22
	30 – 39	2	2	4	
	40 – 49	7	7	14	
	50 – 59	1	0	1	
Substance misuse	Illicit drugs only	1	5	6	22
	Alcohol only	5	5	10	
	Illicit drugs and alcohol	5	1	6	
Residential service	Service A	11	0	11	22
	Service B	0	11	11	
Residential treatment stage	Welcome House (WH)	5	5	10	22
	Main treatment (after WH)	2	1	3	
	Completed WH and main treatment successfully	2	1	3	
	Left WH prematurely	2	0	2	
	Left main stage of treatment prematurely	0	4	4	
Detoxified in service	Yes – detoxified in WH	2	6	8	22
	No – detoxified before arrival	9	5	14	
Previous residential treatment	Yes – same provider	2	0	2	22
	Yes – different provider	4	2	6	
	No	5	9	14	